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'None of my providers have the slightest clue what to do with me': Transmasculine individuals' experiences with gynecological healthcare providers

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ABSTRACT

Background: Transgender individuals experience barriers to accessing healthcare including financial difficulties, lack of insurance, and discrimination and victimization by medical providers. Transmasculine patients face unique challenges and are more at risk for reproductive pathology resulting from a lack of regular gynecological care. Presently, a dearth of research exists on the needs of transmasculine patients in gynecological healthcare settings. While the literature on experiences of transmasculine individuals has focused on physical health and risk factors for this population, this study focuses on the information that transmasculine individuals want their gynecologists to know when working with trans patients.

Aim: The aim of the present study was to explore the lived experiences of transmasculine individuals in order to understand what they feel their medical providers need to know about their experiences seeking gynecological care.

Method: Participants included 167 adults who identified as masculine of center or trans men ranging in age from 18 - 56 (M = 27.99, SD = 6.06). Participants completed an online survey and responded to open-ended questions about their gynecological healthcare experiences. Qualitative responses were analyzed via thematic analysis.

Results: Results revealed four information-salient themes, including: 1) Patient comfort levels; 2) Language; 3) Provider assumptions; and 4) Provider knowledge.

Conclusions: Findings suggest that gynecologists are key in both exacerbating barriers and creating more affirming spaces for transmasculine patients. Discussion of the results focuses on the ways that providers can improve the gynecologic healthcare experiences of their transmasculine patients.

KEYWORDS

Gynecological care; thematic analysis; transgender; transgender men

The present study explores the information that transmasculine individuals want their gynecologists to know about working with trans patients. *Transgender* (or trans) people experience their gender identity as different from the sex that they were assigned at birth. Gender identity is commonly thought of as an individuals' inherent sense of gender, and how closely they refer to being male, female, both, or neither (Tate et al., 2014). Cisgender (or cis) individuals closely identify with the sex they were assigned at birth, whereas trans individuals may seek a medical gender transition, including cross-gender hormone therapy or gender affirmation surgeries in order to better align their physical body with their experienced gender (Deutsch & Feldman, 2013). This process may look different for each person who pursues it, and it is important to note that there is no such thing as a *typical* gender transition. Although trans identities have traditionally been conceptualized as binary (e.g., trans women or trans men; American Psychiatric Association [APA,] 2000), many trans individuals conceptualize their gender as *non-binary*, and identify as a blend of genders, or have a gender that fluctuates or varies among multiple genders (Galupo et al., 2017). The present study focuses specifically on *transmasculine* individuals, or

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individuals who were assigned female at birth who identify with either a binary gender of male or a non-binary gender that falls masculine-of-center (Hansbury, 2005).

Trans health disparities

Trans individuals face unique health disparities. Prior research has documented a high prevalence of adverse health outcomes, such as mental health distress, substance abuse, HIV, and other sexual disorders, including sexually transmitted infections and cancers affecting the reproductive organs (Reisner et al., 2014). Further, trans individuals often have limited access to resources that allow them access to medical care and doctors. In the United States Transgender Survey (USTS), 33% of those surveyed acknowledged an inability to afford medical care. Twenty-nine percent of those surveyed lived below the poverty line – further emphasizing that many trans individuals do not have access to financial resources to obtain necessary medical care (James et al., 2016). Trans individuals are also considered to be more at risk for mental health issues (e.g., depression; Brown & Jones, 2016) as well as physical health issues (James et al., 2016).

Previous studies concerning the gynecological care of transmasculine patients have centered on endocrinology studies (Velho et al., 2017), case reports of traditionally female diseases reported in transgender men (Dutton et al., 2008), and pregnancy and fertility preservation (Maxwell et al., 2017). While it has been documented that transmasculine clients are more at risk for cervical cancer (Rollston, 2019), human papillomavirus, and other reproductive pathology (Hernandez et al., 2020), much of the increased risk is derived from a lack of regular gynecological care. One barrier to receiving support is a lack of financial resources. As trans individuals are more likely to live below the poverty line (James et al., 2016), they are also less likely to have medical insurance. Another barrier to accessing services may be the individuals' own feelings of gender dysphoria, or the distress that results from having an experienced gender that does not align with one's assigned sex (APA, 2013). Feelings of gender dysphoria can stem from either situational triggers (Galupo et al., 2020) or from explicitly gendered situations or environments (Pulice-Farrow, Segiel, & Galupo, Under Review). This gender dysphoria may present as physical symptoms (e.g., stomachaches) or emotional distress (e.g., feelings of despair; Pulice-Farrow et al., 2019). As gynecologists deal directly with body parts that may not align with a transmasculine patient's gender identity, accessing these medical services may result in increased levels of distress for trans patients.

A further barrier to transmasculine individuals obtaining gynecological healthcare is that trans individuals face disproportionate discrimination and victimization by medical providers. Over 33% of participants in the USTS reported harassment or refusal of treatment by a medical provider in the last year (James et al., 2016) with trans People of Color being more likely to experience this discrimination when compared to their White counterparts (Kattari et al., 2015). Further, many trans individuals are refused access to medical care once the provider becomes aware of the individual's trans identity (Grant et al., 2011).

Many trans individuals acknowledge delaying healthcare due to either previous trauma or a disinterest in being discriminated against from healthcare providers. Since trans individuals are more likely to be the survivor of a physical or sexual trauma than cis individuals (James et al., 2016), trans patients often present to gynecologists with preexisting traumas (Flynn, 2019). Gynecological care, then, may trigger strong feelings of gender dysphoria or a trauma response, due to the practice focusing on the health of body parts that may be both closely associated with sexual assault and experiences of gender dysphoria (Aiken, 2016). Previous studies (e.g., Flynn, 2019) have argued for gynecologists to practice trauma-informed care for their trans clients.

Discrimination of trans patients by medical providers is the result of a variety of factors including: cisgenderism, or explicit discrimination against trans individuals (Ansara & Berger, 2016); implicit biases against trans individuals; or to a provider's discomfort with working with trans individuals (Shires et al., 2018). In a recent study conducted by Shires et al. (2018), 85.7% of doctors acknowledged that they were willing to provide routine healthcare to trans individuals. Further,

Table 1. Participant demographics.

	Total (N = 157)
Age Mean (SD)	27.99 (6.06)
Sexual Orientation (%)	
Queer	34.13
Bisexual	17.37
Pansexual	16.17
Gay	14.95
Asexual	6.59
Heterosexual	4.19
Lesbian	3.59
Other	2.40
Fluid	0.59
Socio-Economic Status (%)	
Working Class	36.53
Lower-Middle Class	16.17
Middle Class	26.35
Upper-Middle Class	7.78
Upper Class	3.59
Other	2.40
No Answer	7.18
Education (%)	
Four-Year Degree	41.32
Some College	22.16
Professional Degree	13.77
Two-Year Degree	7.18
High School Diploma/GED	7.18
Doctorate/Professional Degree	6.59
Less than a High School Degree	1.80
Race/Ethnicity (%)	
White/Caucasian	89.22
Biracial/Multiracial	5.99
Asian/Asian American	2.40
Hispanic/Latinx	1.19
Native Hawaiian/Other Pacific Islander	0.60
Other	0.60

only 78% of those surveyed were willing to perform routine gynecological exams (e.g., Papanicolaou tests) on trans men (Shires et al., 2018). These results are startling – medical providers are bound by their own ethics to help their patients and refer out only when necessary, yet these statistics show that many doctors are willing to go against their ethics code when coming into contact with a patient they feel uncomfortable with. These statistics stand in stark contrast to various online blogs and academic papers that underscore the importance of transmasculine individuals obtaining gynecologic care (see Dutton et al., 2008; Unger, 2014, 2015). However, Shires et al. (2018) did find that the more educated a healthcare provider was regarding trans issues, the more likely they were to treat a trans patient.

Statement of the problem

Presently, there is a dearth of scholarship surrounding the needs of transmasculine patients in gynecological healthcare settings. The literature that presently exists typically has small sample sizes, focuses on the (typically cisgender) medical providers, or has an overt focus on health outcomes or the patients' bodies. This focus on the body, while important in a reproductive healthcare setting, may be dismissive of transmasculine individuals' identities and experiences, as these studies typically fail to center the voices and experiences of transmasculine individuals. Further, these studies may have an unintentional consequence of inadvertently leading transmasculine patients to delay seeking gynecologic care. The present study seeks to center transmasculine individuals' experiences, and utilizes one of the largest sample sizes of transmasculine individuals to do so. We set out to specifically explore the narratives of transmasculine gynecological patients in order to understand their experiences, and focused on how to improve gynecological care for them. The research question guiding the current study was: *What do transmasculine individuals want their gynecologists to know about working with trans patients?*

Method

As part of a larger study on experiences of transgender men and masculine of center people with gynecological care, the current study utilized an online survey to explore the experiences of transmasculine and non-binary people in gynecological settings. Online surveys have long been established as an effective medium for qualitative research (e.g., Kazmer & Xie, 2008) and were used in the current study to protect the identities of the trans participants (See Riggle et al., 2005). An inductive semantic criticalist approach to reflexive thematic analysis (Braun & Clarke, 2006) was used to analyze the data because the authors were most interested in reporting patterns of experiences across participant responses by focusing on the explicit content provided by participant narratives in the data analysis process. This study was approved by the institutional review board (IRB) at University of Tennessee, Knoxville.

Participants and procedure

Participants in the study ($N = 167$) were over the age of 18, and identified as transgender and

Table 2. Thematic structure and percentage of sample endorsing each theme.

Theme	Percent of Sample Endorsing Theme
Patient Comfort Levels	29.1%
Language	60.5%
Provider Assumptions	32%
Provider Knowledge	32%

masculine of center. Participants ranged in age from 18 to 56 ($M = 27.99$, $SD = 6.06$) and identified as transmasculine ($n = 101$, 60.48%), non-binary ($n = 59$, 35.33%), and agender ($n = 7$, 4.19%). Twelve participants (7.19%) identified as intersex. There was limited racial and ethnic diversity within the sample, with 89.22% identifying as White/Caucasian and 10.88% identifying as a racial or ethnic minority. Table 1 displays the sample's demographics, including highest level of education, sexual orientation, and socio-economic status.

As part of a larger study on experiences of transgender and masculine of center people with gynecological care, participants completed an online survey. Digital flyers advertising the study were posted to Facebook, Twitter, and Reddit pages (e.g., r/FtM, The Trans Man Network, etc.), and participants were encouraged to share the flyer with the survey link within their communities. Participant responses were collected from January of 2020 through March of 2020. Individuals interested in taking the survey answered a set of demographic questions and then responded to a series of open-ended questions about their experiences with gynecological care. Following the participants' completion of the survey, the researchers analyzed one open-ended prompt from the larger survey. This prompt was, '*What information do you believe is most important for medical providers to know?*'

The researchers in the current study had diverse experiences and identities across gender identity, gender presentation, sexual orientation, race, and ethnicity. Two of the three research team members identify as transgender and masculine of center. All researchers have expertise in qualitative research and have coauthored multiple peer-reviewed papers based on qualitative work.

Data analysis

An inductive semantic criticalist approach to reflexive thematic analysis (Braun & Clarke, 2006) was used to analyze participant responses to the open-ended question about what they would want medical providers to know about their experiences. Data analysis followed the steps identified by Braun and Clarke (2006) where analysis began with the first and the third authors reading through participant responses and coding the data independently. The first and third authors independently categorized and grouped together similar words and clauses from participant narratives based on related ideas or meaning units (Giorgi, 1985) to form preliminary themes. Then, the first and third author met to discuss these codes and agree on preliminary themes. The second author served as the auditor and reviewed the themes and provided feedback about the themes to the other authors. All three authors then met to revise and finalize the themes. The first and third authors then coded the participants' quotes based on themes. The research team met weekly during the coding process (spanning a month) to discuss discrepancies, revise the thematic structure, and solidify a final set of themes.

Results

While participants described their gynecological providers' knowledge about working with transmasculine patients, many of these responses were framed through the lenses of both gender dysphoria and trauma. Participants named their gender dysphoria: '*Some of us have crippling dysphoria about our genitals and seeing a gyno is even more of an uncomfortable reminder of that dysphoria - be patient with us*' (White man of trans experience, 26). Even though many of the participants' gender dysphoria-specific discussions occurred within the context of another theme, the fact that the participants named these experiences directly suggest that their gender dysphoria was salient within the present dataset. Trauma was also a salient aspect of participants' experiences, and this was seen through participant responses. One participant noted that they wanted providers to know, '*How absolutely terrible it is to have to go to the gyno. How embarrassing and trauma inducing it is*' (White male,

30), and evoked doctors to '*be trauma sensitive*' (White trans male, 27).

The present analysis focused on participants' responses to one open-ended prompt. Specifically, they were asked to describe the information that they wished gynecological providers knew about working with transmasculine patients. Thematic analysis revealed four major themes: 1) *Patient comfort levels*; 2) *Language*; 3) *Provider assumptions*; and 4) *Provider knowledge*. Table 2 illustrates the thematic structure along with the percentage of the sample expressing each theme. The results are described using direct quotes from the participants, and are contextualized with the participant's self-identified race, ethnicity, gender identity label, and age. It is important to note that race, ethnicity, and gender identity were asked in an open-ended format. While we acknowledge that some of the labels may conflate ethnicity and race, or ethnicity and religion, our categories specifically reflect the labels that our participants used to describe their various identities.

Patient comfort levels

Patient comfort levels (reported by 29.1% of the sample) was the first theme that participants used to describe what they wanted their gynecological providers to understand about working with transmasculine patients. This typically meant engaging in actions such as having conversations with patients in order to assess how comfortable they were, being aware of potential patient discomfort, or creating a more trans-friendly environment. Participants noted that these comfort levels may be different than what providers were used to with cisgender women. This theme was expressed through four subthemes: *pre-exam discussions, awareness of patient discomfort, flexibility of exams,* and *physical environment.*

Pre-exam discussions

Within this subtheme, participants described instances in which they desired pre-exam discussions with their medical providers. One participant noted, '*that a trans person will probably [be] apprehensive about exams and it helped to know what the doctor was doing/what was going to happen as it was happening*' (Hispanic/Latinx male, 31), while a second wanted providers to, '*explain procedures before performing them and explain the benefits of why this procedure should be done*' (White male, 35). Many participants described desiring specific protocols in which providers could provide consistent information to the patient.

Further, many participants described practitioners negotiating active consent with their transmasculine patients as a demonstration of a way that providers could enhance patient comfort levels. Participants stated that providers should ask for, '*Active consent for when they touch you*' (White male, 37). One participant stated, '*Explain exactly what will happen before the exam and talk through so [the patient] knows what's happening. Just be kind and respectful like you would for all patients*' (White trans non-binary person, 36).

Participants also described wanting their gynecologist to allow for and have discussions about flexible exams. One participant stated, '*[Providers] should learn to be very patient with us. An exam might have to be shorter, or there might need to be more breaks during it*' (White non-binary person, 23). Another participant encouraged providers to allow patients to take a focal role in their own training, suggesting, '*Let [patients] say if they need a break at any point*' (White male demiboy, 23).

Awareness of patient discomfort

Some participants described wanting providers to know that transmasculine patients might experience different types of discomfort than other patients, and described general recommendations for managing this discomfort within an exam setting. These suggestions ranged from a general desire for providers to have an, '*understanding of how to alleviate the distress of gynecological exams for transmasc[uline] individuals*' (White non-binary person, 28), to other participants stating '*some transmasculine people may be extremely uncomfortable with penetrative gynecological exams*' (White genderqueer person, 43). Other participants took the opportunity to underscore the psychological and emotional distress they experienced from a trip to a gynecological

healthcare provider. One participant described their reaction to their visit to the gynecologist:

> *I'm often so anxious by the time I get through the waiting room and into a gynecology appointment that I'm much less able to communicate and advocate for myself … Just being cognizant that your patient is probably deeply uncomfortable in the setting. Any gesture toward making me more comfortable is deeply felt* (White man, 26).

Physical environment

The final comfort-related subtheme capturing participant responses focused on the physical environment of the office or clinic. For participants, the environment of being in what was perceived as an all-women space felt uncomfortable. One participant stated:

> *Private spaces to share PRIVATE medical info are so important. An alternative waiting area without pregnant women or babies would be so helpful. Seeing SO MANY pregnant women and babies can be triggering for some trans individuals … and those individuals still deserve healthcare!* (White genderfluid, masc-leaning person, 27).

Another participant, a 28-year-old White masc-leaning person, emphasized the need for privacy:

> *I should be able to walk into a GYN office, my gender not assumed at the front desk, not be assaulted by photos of women and babies everywhere, brought back to a PRIVATE SAFE space to share my history and identity, before seeing a doctor who is open and willing to treat all gender identities and not discriminate for testing or procedures.*

One participant succinctly named the repercussions of experiencing environmental microaggressions against trans individuals, stating, '*We often stay silent in places that are strongly coded female even when we're uncomfortable because we don't want to start a fight or risk our health care*' (White transgender man, 29).

Language

The second theme that participants used to describe information that they wished their gynecological provider knew was focused on language. Participants highlighted how utilizing specific language could make their gynecologist visits feel more comfortable and affirming of their transmasculine identities. This theme was acknowledged by 60.5% of participants and was expressed through four subthemes: *body labels, names and pronouns, forms and paperwork,* and *women-only language.*

Body labels

Participants used their responses to underscore that they wished providers would use different language to describe their bodies. Participants reflected that different individuals, transmasculine or not, may have different language for their body parts and reproductive organs. One participant stated, '*People refer to their anatomy in different ways. It's important to establish what terms are comfortable for the patient while still communicating health information clearly*' (White man, 20). A second participant suggested that it might be '*best to ask the person how they want their genitals referred to*' (White non-binary person, 25). Another agreed, saying, '*try to use language that [patients] are comfortable with*' (White male demiboy, 23).

Participants also directly suggested that providers use less-gendered language for genitals and secondary sex characteristics. One participant exemplified this finding when he stated that '*organs have no gender*' (White male, 26). A 29-year-old white male stated:

> *It's important to ask each patient how they feel about their parts! Some, you can say vagina and uterus and it doesn't make them react negatively in any way. But for others, those words can ruin their entire day.*

Names and pronouns

A second subtheme reflected the importance of providers using appropriate names and pronouns of trans patients. Participants acknowledged feeling demeaned or anxious when a provider used a birth name instead of a chosen name, or when they were misgendered in a provider's office. One participant described this more fully, saying, '*Even if nothing they've said has been dismissive or even unintentionally transphobic, being misgendered just shows me they don't really know how to interact with me or other trans individuals*' (White trans man, 22). Another participant suggested having gynecological providers model appropriate name

and pronoun usage. '*Introducing yourself with name and pronouns and asking the patient for theirs is a good way to set someone at ease*' (White male, 26).

Forms and paperwork

Participants also described having gender-neutral or non-female options on paperwork and forms at their gynecological provider's offices as a way to make visits more comfortable. A few participants noted frustration with their providers, with one saying that their gynecological providers should, '*actually read the intake sheets that you have us fill out with gender and pronouns*' (White genderqueer person, 24). Participants suggested, '*have the option [of writing] preferred name and pronouns on the [office] paperwork*' (White transmasculine person, 20) that could make trans patients feel more comfortable. Other participants described the desire to be able to come out as transmasculine on forms and paperwork within the office:

> *You should provide an opportunity for [patients] to let the office know important things like their gender, their name (even if they are still legally known as their dead name), and their pronouns. Having areas to put this information into the office paperwork is something that has really helped me at other health care providers' offices* (White man, 36).

Women-only language

The final way in which participants expressed the desire for gynecological providers to change their language was through the use of women-only language. Many gynecological spaces may be known as 'women's clinics' or have names that underscore how the services provided are meant only for women. Participants acknowledged a desire for their providers to stop using this language, recommending that providers, '*not refer to services as 'women's health' or anything like that*' (White non-binary person, 27). One participant described the subtheme by stating, '*things do not need to be labeled as being 'for women' for the intended audience (including non-women for whom something is applicable) to understand what is meant*' (White transmasculine person, 28).

Provider assumptions

Participants discussed provider assumptions as something they wanted providers to know about working with trans patients. Many participants described wanting their providers to understand that they were not a monolith for the transmasculine community, and that they should be treated as individual patients with unique issues and desires. Participants also expressed the desire for their gynecological providers to understand that transmasculine patients were as heterogeneous as their cisgender patients. The theme was expressed in two subthemes: *partner and sex preference,* and *'one size fits all' care.* This theme was acknowledged by 32% of the sample.

Partner and sex preference

Participants challenged providers' assumptions that there is one type of sex or sexual partner for trans patients. One participant stated, '*Be mindful of assumptions that you may make about trans patients, particularly around sexual partners, sexual activity, and reproductive goals*' (White man, 29). A second participant agreed when they said, '*Don't assume all trans men sleep with women. Don't assume we need to or do receive medical care such as hormones, top surgery, etc.*' (White non-binary transmasculine person, 30).

Some providers' assumptions could be seen through the type of information that was disseminated to their patients. One participant stated:

> *Trans men need to be educated about PrEP and offer it unless they do not anticipate ever engaging in activities that could potentially result in HIV transmission in the future. They also need to be educated about contraception and offered it* (White trans guy, 28).

'One size fits all' care

The second subtheme was the desire for their gynecological providers to understand that, for transmasculine patients, there is no such thing as 'one size fits all' care. Some participants described the subtheme through underscoring that transmasculine individuals are not the same as cisgender women: '*you can't just apply a cis-woman approach to care for a transmasculine person*' (White nonbinary/transmasculine person, 29). Another participant noted that, '*trans men's reproductive systems,*

on T, are not the same as cis women' (White transsexual male, 25). Participants also rejected the idea of 'one size fits all' care through challenging the assumption that all transmasculine people were the same. A participant stated:

> *[Gynecological] staff need to stop assuming that the desires for what trans people want out of their bodies, sexuality, and reproductive health are the same. Some have greater degrees of dysphoria than others. Some want to medically transition, some don't, some do but only to certain degrees. Some want to bear children, some don't. We all have different sexualities and prefer to have sex (or not have sex) in ways unique to our preferences or traumas, just like cis people* (White demimale, 30).

Finally, participants emphasized that transmasculine patients could be transmasculine even without pursuing medical transition. One participant succinctly stated, '*Even though I have not transitioned yet, I still am transmasculine*' (White masc enby, 21). Another 20-year-old White male stated:

> *Transmasculine people are more common than [gynecologists] think. It's important that they consider the people they're treating may be transmasculine even if they don't pass. Transmasculine people are often very afraid to come out to a gynecologist because it is an incredibly vulnerable position to be in and they have likely already experienced medical abuse.*

Provider knowledge

The final theme from participant responses centered on provider knowledge. In this theme, participants described the information they wished their medical providers knew, instead of relying on their transmasculine patients for education. This theme was endorsed by 32% of the sample, and encompassed four subthemes, including: *microaggressions and discrimination, patients as educators, family planning and birth control,* and *effects of testosterone.*

Microaggressions and discrimination

Many participants in the sample described wanting their gynecological providers to understand the discrimination and stigma, often in the form of microaggressions, that they faced as transmasculine individuals in gynecological settings. Participants wanted their gynecological providers to understand, '*the discrimination that many LGBTQ individuals have faced overall and within healthcare settings*' (White male, 34) and desired the option to, '*see a doctor who is open and willing to treat all gender identities and not discriminate for testing or procedures*' (White genderfluid masc-leaning person, 47). Other microaggressions included, '*misgendering*' (White transmasculine person, 22), '*deadnaming*' (White male, 36) and a general absence of '*transgender sensitivity training*' (White male, 22).

Other participants described microaggressive behavior from healthcare providers. One participant said, '*it's okay to be "uncomfortable" … trust us, it's very uncomfortable for us. But you don't have to be rude by bringing up unrelated things. My 'real' name has nothing to do with the examination*' (White non-binary person, 21).

Other participants echoed this sentiment, with one asserting, '*providers should not solicit information from a trans patient that they do not need to know for some specific medical purpose. They should not solicit information solely out of curiosity*' (White male, 28). Participants also noted non-verbal microaggressions from their gynecological providers. One participant stated, '*Be aware of staring. I get that a lot*' (White male, 47) while another participant said, '*We are not freaks or zoo animals to be viewed and discussed. Honestly, I'd rather be visually ignored than stared at when in between the waiting room and exam room*' (White trans male, 31).

Patients as educators

Participants requested that their gynecological providers know more than they did about their bodies. Participants noted frustration with their providers, with one participant saying that they wanted their doctor to, '*actually know what trans and gender variants are. I regularly have to teach my own doctors what that means and the other types under the umbrella. It's exhausting and leads to nervousness about care*' (Jewish transmasculine person, 24). Another participant stated that, '*patients [are] here for a problem, not to be belittled and educate you*' (White agender dyke, 27), while a third stated, '*I want to feel like my doctors are more educated than I am. None of my providers have the slightest clue what to do with me*'

(White male, 27). It is important to note that this frustration was not universal among participants in this study. Some participants acknowledged being 'okay' with advocating for themselves: *'I don't necessarily mind having to advocate for myself and educate my doctors on what it is I need from them as a trans man, especially being in a rural area'* (White trans man, 22).

Family planning and birth control

Many participants described that their visits to gynecological centers did not provide them with options regarding family planning and birth control. Many patients found themselves educating their providers on this topic, stating that, '*testosterone is not a form of birth control*' (White man, 20) and that, *'some knowledge of birth control options would be helpful'* (Biracial trans male, 29). Other participants described being, *'pressured to go on birth control'* (White nonbinary/transmasculine person, 33) by their providers, which was an uncomfortable experience.

Participants also described wanting to, '*understand fertility options*' (Asian/Asian-American non-binary person, 29), while others named receiving misinformation from their providers, *'[I was] informed about "infertility" with hormones. It's not a sure thing and [my provider] made me feel like I would never have biological kids even when many trans people do'* (White male, 24). Participants wanted their providers to understand that, '*trans men can get pregnant*' (White genderfluid person, 26). Another participant noted the heterogeneity of the desires of trans individuals, and how gynecological providers could do more to inform their patients:

> *Some folks may be averse to the idea of pregnancy or being fertile … while others might be seeking ways to become pregnant or otherwise desire increased fertility* (White demi-male, 33).

Effects of testosterone

The final subtheme that was brought up about provider knowledge was the desire for gynecological providers to understand what the effects of testosterone were for trans patients. Many patients had to educate their doctors about testosterone and were frustrated about not being able to attain information regarding medical transition steps. The information that participants wanted to obtain from their gynecological providers included, *'effects of HRT on reproductive organs, possible threats to health they might entail'* (White trans male, 28), and, *'how medical transition steps (HRT, surgeries, etc.) effect my health care needs'* (White non-binary person, 29). Other participants stated that they wanted providers to understand how testosterone effected their bodies during gynecological appointments, including, *'the physical impact of testosterone on the vagina leading to atrophy and painful Pap smears,'* (White trans male, 28) and, *'for the love of god, use extra lube. Testosterone can make it dry as a desert down there'* (White queer person, 27). Research on the effects of testosterone on uterine or ovarian tissue is in its infancy, and participants described wanting their gynecological provider to understand the various effects of testosterone and be able to competently answer their questions.

Discussion

The present study sought to understand what transmasculine gynecological patients wanted their healthcare providers to know about working with trans patients, and contributes novel information to the gynecological literature. Previous studies concerning the gynecological care of transmasculine patients have focused on endocrinology studies, case reports of traditionally female diseases reported in transgender men, and implications for health research. While this literature provides a foundation for the field, the current published scholarship illustrates the pervasive focus on outcomes of gynecological healthcare for this population while failing to center their lived experiences. The current study's results indicate that transmasculine patients consistently want their gynecologists to understand certain aspects of their experiences and bodies in order to provide safer and more affirming gynecological support. Providers who do not engage in active education to understand their own implicit biases or work to actively understand the differential needs of their transmasculine patients do a disservice to the patients they are trying to assist. Thus, providers

should continue to reflect on their own implicit and explicit biases regarding transmasculine patients so that they can better affirm and assist the transmasculine population.

This study demonstrates an important contribution to the gynecological and medical literature. Whereas previous studies have typically had small sample sizes, centered the experiences of medical providers, or only focused on the patients' body, the present research specifically focused on transmasculine patients' experiences with their care providers, and did so using one of the largest sample sizes in this type of study. Further, this study allowed us to understand that gynecologists are key in both exacerbating barriers and creating more affirming spaces for their trans patients in order to reduce the barriers that result in health disparities for trans individuals. Our findings offer gynecological providers and their staff the opportunity to reflect on and analyze their current clinical practices regarding patient comfort levels, language used, provider assumptions, and provider knowledge to determine areas of strength and areas for improvement for their clinic or facility.

Basic respect and care

Seeking and receiving access to gynecologic care can be a challenge for many individuals, and participants reported basic respect and care from their provider as one of the specific barriers. Transmasculine individuals may struggle with accessing gynecologic care due to a myriad of reasons, but results of the present study show easy ways for gynecologists to lower the barriers to accessing care for these patients. Participants acknowledged desiring basic respect and care from their healthcare providers. This was expressed through the themes of *Language* and *Patient Comfort Levels*. In the *Language* theme, participants expressed desiring their providers to use their correct names and pronouns, something that should be done for all patients. Further, as seen in the *Patient Comfort Level* theme, participants wanted to be engaged in conversations concerning what occurs during their exam, and have their providers acknowledge that seeing a gynecologist may be an uncomfortable experience emotionally and physically for them.

These levels of respect and care should be assumed to be true for all patients. However, trans individuals typically have a harder time accessing medical care than their cisgender counterparts. Specifically, trans individuals may be refused treatment by medical providers and thus may avoid medical practitioners altogether (Bauer et al., 2009). Trans individuals are more likely than cisgender individuals to have medical providers who harass, assault, or microaggress them (Dean et al., 2016), and may be put at risk simply by the healthcare environment (Freeman, 2018). By understanding how misgendering, misnaming, and denial of lived experience could work in tandem to feel disrespectful to transmasculine patients, gynecologists could work to make their environment more friendly to trans patients through using correct names and pronouns. Given the stigma and fears that trans patients have regarding gynecological healthcare, gynecologists should engage in public health outreach efforts in order to build partnerships and relationships with trans organizations. This will allow an increase in trust and access to care.

Provider knowledge and assumptions

Another barrier to receiving services that participants repeatedly named was situated within the providers themselves - specifically, the provider's preconceived assumptions or lack of knowledge regarding trans individuals. Participants mentioned that they wanted to feel as though their gynecologist was more educated than they were. Similarly, they also wanted part of that knowledge to be reflected by providers' understanding that transmasculine individuals were not a monolithic group, and that one-size-fits-all care might not be applicable for them. In order to provide a basic level of competent care, gynecologists should be intentional to engage in learning about their transmasculine-identified patients.

A provider with a lack of knowledge concerning transmasculine individuals may microaggress their patients (Forbes-Roberts, 2018) or may provide patients with incorrect information regarding their bodies and transition decisions (Hines

et al., 2019). These biases may further lead providers to feel less comfortable with working with transmasculine patients, which then bleeds into the patient-practitioner relationship (Safer et al., 2016). Providers who do not engage in appropriate trainings in order to establish competency around working with trans clients do nothing but perpetuate the vast system of barriers in place against these clients. Further, providers should engage with the present body of literature concerning transmasculine patients, outcomes of hormone replacement therapy, or the available literature concerning the effects of testosterone on the body.

Limitations and future directions

The present study is not without limitations. First, our participants represent an online convenience sample, which can over-represent White, educated, and middle-class participants (Christian et al., 2008). The present sample is no exception, and results should be viewed within the context of these limitations. Future research should seek to understand the unique actions that transmasculine People of Color specifically need from their gynecologists. As there are few studies that center transmasculine People of Color, the majority of what is understood about experiences of trans individuals comes from a White-dominated framework (de Graaf et al., 2019). However, having an online survey allowed us to reach many transmasculine participants from a community sample. This allowed us to ensure that we did not over-sample participants who had undergone medical transition steps, something that we would have had to consider, as previous research may over-sample clinical settings in which patients have already undergone a full medical transition. Further, utilizing an online survey methodology allowed us to survey over 150 transmasculine individuals from across the United States, and utilizing qualitative feedback allowed us to center the voices of these individuals in a field that so often fails to center the experiences of the clients that are being seen. This study underscores the importance of the use of trans individuals' lived experiences to provide directions for gynecologists. The present findings highlighted that this information could easily be disseminated to gynecologists via a specific training or class. Future studies should seek to create interventions that underscore the aspects of care that participants desired from their reproductive healthcare providers. Further, as much of the literature concerning the effects of testosterone on uterine and ovarian health is still relatively new, gynecologists should view this paper as a call to action. Specifically, we encourage more clinical and histopathological research on the effects of testosterone on uterine or ovarian tissue.

Finally, as this study was specifically focused on transmasculine experiences with gynecological providers, we did not explore transmasculine experiences with other primary care physicians (i.e., family medicine providers, internists, nurse practitioners, physicians' assistants, and informed consent clinic providers). Data concerning the experiences of transmasculine individuals with these other providers would be useful in exploring how transmasculine folks are treated by providers in other care settings. Future research should explore how transmasculine experiences compare across these different care settings.

Conclusion

The present study contributes to scholarship regarding how gynecological healthcare providers can effectively create more affirming experiences for their transmasculine patients. Many transmasculine individuals are treated by gynecologists who have an unclear understanding of the unique needs of this population, which is then perceived to be a barrier to accessing services. This study provides foundational knowledge to gynecological healthcare providers in order to allow them to better treat their transmasculine patients. Future studies should work toward creation of an intervention that specifically targets reproductive healthcare providers to expand their knowledge base of working with patients who are transmasculine.

Disclosure statement

The authors have no conflict of interest to declare.

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